FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032169

Facility Name: Shabbona Healthcare Center

Address: West Commanche St. (Number) Shabbona (City) 60550 (Zip Code)

County: Dekalb

Telephone Number: (815) 824-2194 **Fax #** (815) 824-2188

IDPA ID Number: 363503389001

Date of Initial License for Current Owners: 4/01/1987

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-4580
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	91	Skilled (SNF)	91	33,306	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	91	TOTALS	91	33,306	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	496	986	1,871	3,353	8
9	SNF/PED					9
10	ICF	12,885	8,607		21,492	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,381	9,593	1,871	24,845	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.60%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/01/1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/01/1987 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1,871

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	142,590	10,565	3,841	156,996		156,996		156,996			1
2	Food Purchase		115,455		115,455		115,455	(416)	115,039			2
3	Housekeeping	171,156	51,970		223,126		223,126	(11,141)	211,985			3
4	Laundry	74,400	12,529		86,929		86,929	(6,411)	80,518			4
5	Heat and Other Utilities			70,438	70,438		70,438	1,128	71,566			5
6	Maintenance	42,977	11,227	13,327	67,531		67,531	320	67,851			6
7	Other (specify):*											7
8	**TOTAL General Services**	431,123	201,746	87,606	720,475		720,475	(16,520)	703,955			8
	B. Health Care and Programs											
9	Medical Director			1,000	1,000		1,000		1,000			9
10	Nursing and Medical Records	950,932	13,253	110,228	1,074,413		1,074,413	10,635	1,085,048			10
10a	Therapy			84,009	84,009		84,009		84,009			10a
11	Activities	81,120	3,606		84,726		84,726		84,726			11
12	Social Services	76,183		3,243	79,426		79,426		79,426			12
13	Nurse Aide Training											13
14	Program Transportation			380	380		380		380			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,108,235	16,859	198,860	1,323,954		1,323,954	10,635	1,334,589			16
	C. General Administration											
17	Administrative	45,750		133,950	179,700		179,700	(60,143)	119,557			17
18	Directors Fees											18
19	Professional Services			20,873	20,873		20,873	13,753	34,626			19
20	Dues, Fees, Subscriptions & Promotions			4,865	4,865		4,865	57	4,922			20
21	Clerical & General Office Expenses	48,651		35,027	83,678		83,678	39,125	122,803			21
22	Employee Benefits & Payroll Taxes			263,208	263,208		263,208	842	264,050			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,689	1,689		1,689	47	1,736			24
25	Other Admin. Staff Transportation			6,875	6,875		6,875	161	7,036			25
26	Insurance-Prop.Liab.Malpractice			9,184	9,184		9,184	763	9,947			26
27	Other (specify):* **Mgt. Alloc.-Benefits**							8,295	8,295			27
28	**TOTAL General Administration**	94,401		475,671	570,072		570,072	2,900	572,972			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,633,759	218,605	762,137	2,614,501		2,614,501	(2,985)	2,611,516			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.** **SEE ACCOUNTANTS' COMPILATION REPORT**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Shabbona Healthcare Center #0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			41,541	41,541		41,541	71,091	112,632			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,277	63,277		63,277	31,155	94,432			32
33	Real Estate Taxes			42,347	42,347		42,347	5,872	48,219			33
34	Rent-Facility & Grounds			298,935	298,935		298,935	(298,935)				34
35	Rent-Equipment & Vehicles			3,633	3,633		3,633	844	4,477			35
36	Other (specify):*											36
37	**TOTAL Ownership**			449,733	449,733		449,733	(189,973)	259,760			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		41,789		41,789		41,789		41,789			39
40	Barber and Beauty Shops			3,252	3,252		3,252		3,252			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,960	49,960		49,960		49,960			42
43	Other (specify):* Nonallowable Costs			31,997	31,997		31,997	(31,997)				43
44	**TOTAL Special Cost Centers**		41,789	85,209	126,998		126,998	(31,997)	95,001			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,633,759	260,394	1,297,079	3,191,232		3,191,232	(224,955)	2,966,277			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(6,411)	4		8
9	Non-Straightline Depreciation	1,153	30		9
10	Interest and Other Investment Income	(1,495)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(255)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(15,094)	43		18
19	Entertainment				19
20	Contributions	6	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,978)	43		24
25	Fund Raising, Advertising and Promotional	(11,249)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(9,264)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (44,587)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(180,368)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (180,368)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (224,955)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Shabbona Healthcare Center
Provider #: 0032169
01/01/04 to 12/31/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
Lab Expense	(2,880)	43
X-Ray Expense	(397)	43
Trust Fees	(150)	43
Unrealized Gain/Loss on Fair Value	(386)	43
Disallowed Legal Fees	(5,451)	19
	(9,264)	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule 6A		See Attached Schedule 6B		See Attached Schedule 6B		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Services	$	Shabbona Building Associates LLC	100.00%	$ 1,951	$ 1,951	1
2	V	30	Depreciation		Shabbona Building Associates LLC	100.00%	67,784	67,784	2
3	V	32	Interest		Shabbona Building Associates LLC	100.00%	225,800	225,800	3
4	V	33	Real Estate Taxes		Shabbona Building Associates LLC	100.00%	3,500	3,500	4
5	V	34	Rent - Facility & Grounds	298,935	Shabbona Building Associates LLC	100.00%		(298,935)	5
6	V	43	Other		Shabbona Building Associates LLC	100.00%	386	386	6
7	V	32	Interest Income	63,277				(63,277)	7
8	V	32	Amortization of Mortgage Costs				2,921	2,921	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 362,212			$ 302,342	$ * (59,870)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Shabbona Healthcare Center
Provider # 0032169
12/31/2004

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes	City
In-State:	
Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis
Out-of-State:	
St. Elizabeth Healthcare Center	Florissant, MO

Other Related Business Entities		
S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

** Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	S.W. Management Co.	100.00%	$ 27	$ 27	15
16	V	3	Housekeeping		S.W. Management Co.	100.00%	52	52	16
17	V	5	Utilities		S.W. Management Co.	100.00%	1,128	1,128	17
18	V	6	Maintenance		S.W. Management Co.	100.00%	320	320	18
19	V	17	Administrative - Salaries	133,950	S.W. Management Co.	100.00%	73,807	(60,143)	19
20	V	19	Professional Services		S.W. Management Co.	100.00%	11,945	11,945	20
21	V	20	Dues, Fees, Subs & Promotions		S.W. Management Co.	100.00%	57	57	21
22	V	21	Clerical - Salaries		S.W. Management Co.	100.00%	35,774	35,774	22
23	V	21	Clerical & General Office Exp.		S.W. Management Co.	100.00%	3,351	3,351	23
24	V	24	Travel and Seminar		S.W. Management Co.	100.00%	47	47	24
25	V	25	Other Admin. Staff Transport.		S.W. Management Co.	100.00%	161	161	25
26	V	26	Insurance-Prop, Liab & Malp.		S.W. Management Co.	100.00%	763	763	26
27	V	27	Mgmt. Allocation of Benefits		S.W. Management Co.	100.00%	8,295	8,295	27
28	V	30	Depreciation		S.W. Management Co.	100.00%	2,154	2,154	28
29	V	32	Interest		S.W. Management Co.	100.00%	710	710	29
30	V	33	Real Estate Taxes		S.W. Management Co.	100.00%	2,372	2,372	30
31	V	35	Rent-Equipment & Vehicles		S.W. Management Co.	100.00%	844	844	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 133,950			$ 141,807	$ * 7,857	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	S & E Medical Supply Co.	100.00%	$ 399	$ 399	15
16	V	3	Housekeeping	2,136	S & E Medical Supply Co.	100.00%	2,136		16
17	V	10	Medical Supplies	957	S & E Medical Supply Co.	100.00%	399	(558)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,093			$ 2,934	$ * (159)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	$	SFO Associates	100.00%	$ 5,308	$ 5,308	15
16	V	32	Interest - Bonds	97,406	SFO Associates	100.00%	91,900	(5,506)	16
17	V	32	Interest - Intercompany	127,998	SFO Associates	100.00%		(127,998)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 225,404			$ 97,208	$ * (128,196)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Sheldon Wolfe	President	Administrative	50.00	See Schedule 7A	4	10.00	Salary	$ 73,807	L17,C7	1
2	Moshe Herman	CFO	Administrative	0.00	See Schedule 7C	2.5	6.25	Salary	10,260	L21,C7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 84,067		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Shabbona Healthcare Center
Providor # 0032169
12/31/2004
Sheldon Wolfe **Schedule 7A**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	3	$ 55,355		$ 55,355
Caseyville Nursing and Rehab	3	55,355		55,355
Franklin Grove Nursing Center	3	55,355		55,355
Kenwood Healthcare Center	12	221,421		221,421
Oregon Healthcare Center	3	55,355		55,355
Shabbona Healthcare Center	4	73,807		73,807
Tower Hill Healthcare Center	4	73,807		73,807
Virgil Calvert Nursing and Rehab	3	55,355		55,355
St. Elizabeth Healthcare Center	1	18,452		18,452
Other	4	73,807		73,807
	40	$ 738,071		$ 738,071

SEE ACCOUNTANTS' COMPILATION REPORT

Shabbona Healthcare Center
Providor # 0032169
12/31/2004
Ronnie Klein **Schedule 7B**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	3.5	$ 5,452	$ 60,000	$ 65,452
Caseyville Nursing and Rehab	3.5	5,452	60,000	65,452
Franklin Grove Nursing Center	5	7,788	90,000	97,788
Kenwood Healthcare Center	20	31,154	210,000	241,154
Oregon Healthcare Center	3.5	5,452	60,000	65,452
Shabbona Healthcare Center	0	-		-
Tower Hill Healthcare Center	0	-		-
Virgil Calvert Nursing and Rehab	4	6,231	60,000	66,231
St. Elizabeth Healthcare Center	0.5	779		779
Other	0	-		-
	40	$ 62,307	$ 540,000	$ 602,307

SEE ACCOUNTANTS' COMPILATION REPORT

Shabbona Healthcare Center
Providor # 0032169
12/31/2004
Moshe Herman **Schedule 7C**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	4.2	$ 17,237		$ 17,237
Caseyville Nursing and Rehab	4.2	17,237		17,237
Franklin Grove Nursing Center	3.4	13,954		13,954
Kenwood Healthcare Center	8.8	36,115		36,115
Oregon Healthcare Center	2.8	11,491		11,491
Shabbona Healthcare Center	2.5	10,260		10,260
Tower Hill Healthcare Center	5.7	23,393		23,393
Virgil Calvert Nursing and Rehab	4.2	17,237		17,237
St. Elizabeth Healthcare Center	4.2	17,237		17,237
Other	0	-		-
	40	$ 164,160		$ 164,160

SEE ACCOUNTANTS' COMPILATION REPORT

s

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.W. Management Co.
Street Address: 7434 N. Skokie Blvd.
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	527,040	9	$ 429	$	33,306	$ 27	1
2	3	Housekeeping	Bed Days Available	527,040	9	820		33,306	52	2
3	5	Utilities	Bed Days Available	527,040	9	17,851		33,306	1,128	3
4	6	Maintenance	Bed Days Available	527,040	9	5,071		33,306	320	4
5	19	Professional Services	Bed Days Available	527,040	9	189,030		33,306	11,945	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	527,040	9	900		33,306	57	6
7	21	Clerical - Salaries	Bed Days Available	527,040	9	566,095	566,095	33,306	35,774	7
8	21	Clerical & General Office Exp.	Bed Days Available	527,040	9	53,023		33,306	3,351	8
9	24	Travel and Seminar	Bed Days Available	527,040	9	750		33,306	47	9
10	25	Other Admin. Staff Transport.	Bed Days Available	527,040	9	2,548		33,306	161	10
11	26	Insurance-Prop, Liab & Malp.	Bed Days Available	527,040	9	12,072		33,306	763	11
12	27	Mgmt. Allocation of Benefits	Bed Days Available	527,040	9	131,259		33,306	8,295	12
13	32	Interest	Bed Days Available	527,040	9	11,228		33,306	710	13
14	33	Real Estate Taxes	Bed Days Available	527,040	9	37,528		33,306	2,372	14
15	35	Rent-Equipment & Vehicles	Bed Days Available	527,040	9	13,358		33,306	844	15
16										16
17	17	Administrative - Salaries	Avg. Hours Worked	40	9	738,071	738,071	4	73,807	17
18	21	Clerical - Salaries	Avg. Hours Worked	40	7	62,307	62,307	0	0	18
19										19
20	30	Depreciation	Direct Cost						2,154	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,842,340	$ 1,366,473		$ 141,807	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S & E Medical Supply Co.
Street Address: 7434 N. Skokie Blvd.
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Cost			$	$		$ 399	1
2	3	Housekeeping	Direct Cost						2,136	2
3	10	Medical Supplies	Direct Cost						399	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,934	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SFO Associates
Street Address: 7434 N. Skokie Blvd.
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Note Receivable	6,500,000	3	$ 20,295	$	1,700,000	$ 5,308	1
2	32	Interest - Bonds	Note Receivable	6,500,000	3	351,383		1,700,000	91,900	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 371,678	$		$ 97,208	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Shabbona Building Assoc.	X		Bonds		7/01/94	$ 1,700,000	$ 1,072,308	8/15/14	0.0665	$ 91,900	1
2	(Loan Payable-SFO Assoc)											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,700,000	$ 1,072,308			$ 91,900	9
	B. Non-Facility Related*											
10							Interest income offset net of intercompany interest				(1,099)	10
11							Amortization of Loan costs				2,921	11
12							SW Management Allocation-Mortgage				710	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,532	14
15	TOTALS (line 9+line14)						$ 1,700,000	$ 1,072,308			$ 94,432	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 43,796	1
	Management Co. allocation	2,372	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 42,643	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,219	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 43,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	Appraisal Fee	$ 3,500	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 48,219	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	38,223	8
	2000	38,904	9
	2001	42,260	10
	2002	41,710	11
	2003	42,643	12

Accrued real estate tax: 42,643 * 1.03 = 43,922

Use = 43,500

SW Management allocation: $2,372

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shabbona Healthcare Center COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0032169

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE (847) 982-2300 FAX #: (847) 982-2304

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-15-327-010	Long-term care properthy	$ 42,643.00	$ 42,643.00
2.	10-28-412-049-0000	SW Management allocation	$ 38,970.00	$ 2,372.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 81,613.00	$ 45,015.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,200 B. General Construction Type: Exterior Brick Frame _____ Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care			$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	91		1994		$ 2,643,587	$	39	$ 67,784	$ 67,784	$ 708,986	4
5											5
6	Management Allocation		1995		27,353		39	782	782	7,545	6
7											7
8											8
	Improvement Type**										
9	Various			1989	2,650	84	20	11	(73)	2,650	9
10	Various			1990	65,810	2,959	20	3,290	331	48,002	10
11	Various			1991	20,535	460	20	1,027	567	15,325	11
12	Various			1992	5,466		10			4,191	12
13	Various			1993	13,848	393	20	685	292	7,798	13
14	Various			1994	39,334	1,009	20	1,967	958	21,209	14
15	Various			1995	13,479	178	20	674	496	7,432	15
16	Various			1996	11,533	160	20	577	417	5,773	16
17	Various			1997	18,996	487	20	949	462	7,411	17
18	Various			1998	141,664	3,693	20	7,021	3,328	48,363	18
19	Various			1999	2,415	62	20	121	59	686	19
20	Air Handler			2000	1,150		10	115		537	20
21	Air Handler			2000	1,870		10	187		857	21
22	Air Handler			2000	1,900		10	190		855	22
23	Driveway			2001	3,040	78	20	152		494	23
24	Nurses Call System			2001	2,745		10	274		962	24
25	Air Handler			2001	1,350		10	135		506	25
26	Security System			2001	1,507		10	151		502	26
27	Telephone System			2001	1,928		10	165		631	27
28	Heating and Cooling System			2002	1,078		20	54		139	28
29	Drapes			2003	1,528		10	153		268	29
30	Sidewalk Repair			2003	1,250		20	62		94	30
31	Wallpaper - North Dining Hall			2004	3,007	19	20	75		75	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Allocation from SW management - leasehold improvements	1995	$ 2,918	$	20	$ 146	$ 146	$ 1,615	37
38	Allocation from SW management - leasehold improvements	1996	510		20	25	25	218	38
39	Allocation from SW management - leasehold improvements	1997	734		20	37	37	366	39
40	Allocation from SW management - leasehold improvements	1998	505		20	25	25	171	40
41	Allocation from SW management - leasehold improvements	1999	1,403		20	70	70	357	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,035,093	$ 9,582		$ 86,904	$ 75,706	$ 894,018	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 134,815	$ 18,296	$ 14,280	$ (4,016)	10	$ 94,026	71
72	Current Year Purchases	10,801	1,278	1,082	(196)	10	1,081	72
73	Fully Depreciated Assets	251,289					251,289	73
74	Allocation of SW Management	7,064		702	702	10	6,017	74
75	TOTALS	$ 403,969	$ 19,574	$ 16,064	$ (3,510)		$ 352,413	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident care	1998 Oldsmobile	1995	$ 21,506	$	$	$	5	$ 20,982	76
77	Resident care	2001 Grand Jeep	2001	33,668	1,775	6,734	4,959	5	17,644	77
78	Resident care	2004 Jeep	2004	25,644	10,610	2,564	(8,046)	5	2,564	78
79	Allocation of SW Mgmt.	2004 Cadillac	2004	3,663		366	366	5	366	79
80	TOTALS			$ 84,481	$ 12,385	$ 9,664	$ (2,721)		$ 41,556	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,573,543	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 41,541	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 112,632	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 71,091	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,287,987	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 3,633 Description: Copiers; $3,633
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	SW Management allocation		$	$ 844	17
18					18
19					19
20					20
21	TOTAL		$	$ 844	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	2,482	$ 37,311	$	2,482	$ 37,311	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		3	165		3	165	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		3,364	46,386		3,364	46,386	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				41,789		41,789	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	5,849	$ 83,862	$ 41,789	5,849	$ 125,651	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,615	$ 8,615	1
2	Cash-Patient Deposits	159	159	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	507,795	507,795	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,752	13,752	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Schedule 17A	(921,421)	180,577	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (391,100)	$ 710,898	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		2,643,587	14
15	Leasehold Improvements, at Historical Cost	320,112	391,506	15
16	Equipment, at Historical Cost	303,348	488,450	16
17	Accumulated Depreciation (book methods)	(354,176)	(1,287,987)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp See Schedule 17A		85,983	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 269,284	$ 2,371,539	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (121,816)	$ 3,082,437	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 30,907	$ 30,907	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,497	1,497	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,013	60,013	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,064	14,064	31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,500	43,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	104,939	2,311,428	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 254,920	$ 2,461,409	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,072,308	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,072,308	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 254,920	$ 3,533,717	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (376,736)	$ (451,280)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (121,816)	$ 3,082,437	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Shabbona Healthcare Center
Provider #:0032169
12/31/04

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	Operating	After Consolidation
Employee Loans	17,047	17,047
Due from The Meadows Ret. Center	163,530	163,530
Due/from Shabbona LLC	(1,101,998)	(1,101,998)
Due to Shabbona Healthcare		1,101,998
Total Line 9 - Other Current Assets (specify):	**(921,421)**	**180,577**

Other (specify):	Operating	After Consolidation
Investment in SFO	0	29,093
Loan Costs	0	87,617
Acc. Amortization of Loan Costs	0	(30,727)
Total Line 23 - Other Current Liabilities (specify):	**0**	**85,983**

Other Long-Term Liabilities (specify):	Operating	After Consolidation
Insurance Premiums Payable	582	582
Acc retirement (From P/R)	1,302	1,302
Short Term Loan Exchange	50,157	50,157
Accrued Expenses	52,898	52,898
Due to/From - SFO		2,206,492
Total Line 36 - Other Long-Term Liabilities (specify):	**104,939**	**2,311,431**

See Accountants' Compilation Report

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (400,600)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (400,600)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	23,864	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 23,864	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (376,736)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,138,668	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,138,668	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	41,646	6
7	Oxygen	1,149	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 42,795	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,352	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	13,724	21
22	Laundry	6,411	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 23,487	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	34	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 34	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	10,112	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,112	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,215,096	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	720,475	31
32	Health Care	1,323,954	32
33	General Administration	570,072	33
	B. Capital Expense		
34	Ownership	449,733	34
	C. Ancillary Expense		
35	Special Cost Centers	77,038	35
36	Provider Participation Fee	49,960	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,191,232	40
41	**Income before Income Taxes (line 30 minus line 40)****	23,864	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 23,864	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Shabbona Healthcare Center
Provider #:0032169
12/31/04

Schedule 19A

XVII. Income Statement

Other Revenue	
Finance Charges	1,461
Flu Shot Income	506
Miscellaneous Income	8,145
Total Line 28 - Other Revenue:	**10,112**

See Accountants' Compilation Report

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,064	2,080	$ 58,144	$ 27.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,297	2,753	77,392	28.11	3
4	Licensed Practical Nurses	11,470	12,567	268,178	21.34	4
5	Nurse Aides & Orderlies	51,764	55,805	547,218	9.81	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,656	7,178	81,120	11.30	10
11	Social Service Workers	4,178	4,420	76,183	17.24	11
12	Dietician					12
13	Food Service Supervisor	2,140	2,174	33,152	15.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,296	14,058	109,438	7.78	15
16	Dishwashers					16
17	Maintenance Workers	2,104	2,174	42,977	19.77	17
18	Housekeepers	18,060	19,509	171,156	8.77	18
19	Laundry	9,175	9,673	74,400	7.69	19
20	Administrator	2,000	2,080	45,750	22.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,441	4,030	48,651	12.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	128,645	138,501	$ 1,633,759 *	$ 11.80	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 3,841	L1, C3	35
36	Medical Director	48	1,000	L9, C3	36
37	Medical Records Consultant	24	228	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	4,591	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	3	147	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	48	3,243	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	315	$ 13,050		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,845	$ 105,409	L10, C3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,845	$ 105,409		53

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Eilene Gates	Administrator	0	$ 45,750
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 45,750

B. Administrative - Other

Description	Amount
SW Management fee	$ 60,000
SW Home Office	73,950
TOTAL (agree to Schedule V, line 17, col. 3)	$ 133,950
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ashman & Stein	legal	$ 5,926
Allen Lefkovitz, Partner	legal	755
Personnel Planners	Unemployment Consultant	694
Frost, Ruttenberg & Rothblatt	Accounting	13,498
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 20,873

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,912
Unemployment Compensation Insurance	62,548
FICA Taxes	124,983
Employee Health Insurance	33,898
Employee Meals	842
Illinois Municipal Retirement Fund (IMRF)*	
Tuition Reimbursement	1,303
Employee Morale	5,564
TOTAL (agree to Schedule V, line 22, col.8)	$ 264,050

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,535
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 69)	824
Dues and Subscriptions	229
Licenses	1,325
Inspections	802
Permits	150
Allocate from SW Management	57
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,922

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,689
Allocate from SW management	47
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,736

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Shabbona Healthcare Center
Provider #: 0032169
01/01/04 to 12/31/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	20,873
Allocated from KTNC Associates	
Legal	1,952
Allocated from SFO Associates	5,308
Allocated from Management Company	
Legal	11,516
Accounting - Frost, Ruttenberg & Rothblatt	429
Professional Services Disallowed	(5,452)
Total (agree to Schedule V, line 19, column 8)	34,626

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shabbona Healthcare Center # 0032169 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **11,193** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **49,960**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **842** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **No**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	142,590	10,565	3,841	156,996	0	156,996	0	156,996
2. Food Purchase	0	115,455	0	115,455	0	115,455	-416	115,039
3. Housekeeping	171,156	51,970	0	223,126	0	223,126	-11,141	211,985
4. Laundry	74,400	12,529	0	86,929	0	86,929	-6,411	80,518
5. Heat and Other Utilities	0	0	70,438	70,438	0	70,438	1,128	71,566
6. Maintenance	42,977	11,227	13,327	67,531	0	67,531	320	67,851
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	431,123	201,746	87,606	720,475	0	720,475	-16,520	703,955
9. Medical Director	0	0	1,000	1,000	0	1,000	0	1,000
10. Nursing & Medical Records	950,932	13,253	110,228	1,074,413	0	1,074,413	10,635	1,085,048
10a. Therapy	0	0	84,009	84,009	0	84,009	0	84,009
11. Activities	81,120	3,606	0	84,726	0	84,726	0	84,726
12. Social Services	76,183	0	3,243	79,426	0	79,426	0	79,426
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	380	380	0	380	0	380
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,108,235	16,859	198,860	1,323,954	0	1,323,954	10,635	1,334,589
17. Administrative	45,750	0	133,950	179,700	0	179,700	-60,143	119,557
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	20,873	20,873	0	20,873	13,753	34,626
20. Fees, Subscriptions & Promotion	0	0	4,865	4,865	0	4,865	57	4,922
21. Clerical & General Office	48,651	0	35,027	83,678	0	83,678	39,125	122,803
22. Employee Benefits & Payroll	0	0	263,208	263,208	0	263,208	842	264,050
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	1,689	1,689	0	1,689	47	1,736
25. Other Admin. Staff Trans	0	0	6,875	6,875	0	6,875	161	7,036
26. Insurance-Prop.Liab.Malpractice	0	0	9,184	9,184	0	9,184	763	9,947
27. Other (specify)*	0	0	0	0	0	0	8,295	8,295
28. Total General Adminis	94,401	0	475,671	570,072	0	570,072	2,900	572,972
29. Total General Administrative	1,633,759	218,605	762,137	2,614,501	0	2,614,501	-2,985	2,611,516
30. Depreciation	0	0	41,541	41,541	0	41,541	71,091	112,632
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	63,277	63,277	0	63,277	31,155	94,432
33. Real Estate	0	0	42,347	42,347	0	42,347	5,872	48,219
34. Rent - Facility & Grounds	0	0	298,935	298,935	0	298,935	-298,935	0
35. Rent - Equipment & Vehicles	0	0	3,633	3,633	0	3,633	844	4,477
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	449,733	449,733	0	449,733	-189,973	259,760
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	41,789	0	41,789	0	41,789	0	41,789
40. Barber and Beauty Shop	0	0	3,252	3,252	0	3,252	0	3,252
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	49,960	49,960	0	49,960	0	49,960
43. Other (specify):*	0	0	31,997	31,997	0	31,997	-31,997	0
44. Total Special Cost Ce	0	41,789	85,209	126,998	0	126,998	-31,997	95,001
45. Grand Total	1,633,759	260,394	1,297,079	3,191,232	0	3,191,232	-224,955	2,966,277

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	8,615	8,615
2. Cash - Patient Deposits	159	159
3. Accounts & Notes Recievable	507,795	507,795
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	13,752	13,752
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	-921,421	180,577
10. Total current assets	-391,100	710,898
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	50,000
14. Buildings, at Historical Cost	0	2,643,587
15. Leasehold Improvements, Historical Cost	320,112	391,506
16. Equipment, at Historical Cost	303,348	488,450
17. Accumulated Depreciation (book methods)	-354,176	-1,287,987
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	85,983
23. other (specify):	0	0
24. Total Long-Term Assets	269,284	2,371,539
25. Total Assets	-121,816	3,082,437
CURRENT LIABILITIES		
26. Accounts Payable	30,907	30,907
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	1,497	1,497
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	60,013	60,013
31. Accrued Taxes Payable	14,064	14,064
32. Accrued Real Estate Taxes	43,500	43,500
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	104,939	2,311,428
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	254,917	2,461,409
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	1,072,308
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	1,072,308
46.Total Liabilities	254,917	3,533,717
47.Total Equity	-376,733	-451,280
48.Total Liabilities and Equity	-121,816	3,082,437

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,138,668
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	3,138,668
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	41,646
7. Oxygen	1,149
Subtotal - Anciliary Revenue	42,795
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	3,352
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	13,724
22. Laundry	6,411
Subtotal - Other Operating Revenue	23,487
24. Contributions	0
25. Interest and Other Investments Income	34
Subtotal - Non-Operating Revenue	34
27. Other Revenue (specify):	0
28. Other Revenue (specify):	10112
Subtotal - Other Revenue	10,112
30. Total Revenue	3,215,096
31. General Services	720,475
32. Health Care	1,323,954
33. General Administration	570,072
34. Ownership	449,733
35. Special Cost Centers	77,038
35. Provider Participation Fee	49,960
37. Other	0
40. Total Expenses	3,191,232
41. Income Before Income Taxes	23,864
42. Income Taxes	0
43. Net Income or Loss for the Year	23,864